Ethics in Psychiatry

Ethical Considerations When Treating Patients with Schizophrenia

by Edmund Howe, MD, JD

INTRODUCTION

Within medicine, some values have changed profoundly over the last few decades. Chief among these is truthfulness—specifically, whether physicians should tell patients the truth when they have a potentially fatal illness, such as cancer. Just decades ago, it was thought that they should not. Now it is thought that they should. Some physicians presently even advocate using advance directives to predetermine whether patients will want to know the truth at a later time.[1,2] The extent to which this value of truthfulness is now given priority is reflected by the current, widespread, ethical consensus that generally doctors should tell patients the truth *even when this may cause foreseeable, additional harm to patients*.

In this commentary, I shall discuss five contexts in which the value of respecting the autonomy of patients with schizophrenia may be in conflict with the values of doing good or avoiding harm. The former is a value not based on the patient's outcome or consequences; the latter two are based on consequences. I suggest that psychiatrists seek to balance these different kinds of values so that in some cases they give greater priority to respecting these patients' autonomy, but in other cases give greater priority to trying to benefit these patients medically as much as they can.

1. TELLING HALF-TRUTHS TO PATIENTS WITH SCHIZOPHRENIA WHO ARE PARANOID

The conflict between truth telling and doing good may be faced by any psychiatrist who considers withholding information from a patient regarding his or her likely psychodynamics or utmost underlying emotional needs. Psychiatrists routinely choose to initially withhold certain types of knowledge because if they disclose everything right away, they run the risk of patients never returning and therefore not receiving adequate care. Ethically, the degree to which a psychiatrist withholds information may disrespect a patient's autonomy and may even be regarded as lying by omission. However, this ethical "price" may be warranted due to other competing and mutually exclusive values that may benefit the patient in other ways.

This same conflict may exist when psychiatrists treat patients

with schizophrenia who have paranoia. Most psychiatrists generally believe that to be maximally effective, they should not directly confront the delusions of patients. Andreason and Black state in their recent basic psychiatric textbook, "A patient with delusional disorder may be more accepting of medication if *it is explained as a treatment for the anxiety, dysphoria, and stress that the patient [has due to] his or her delusions*."[3] [Emphasis added] The use of this partial truth may reduce the risk of avoidable harm, but others have carried this same approach still further. Havens uses a related approach to help establish and then enhance the therapeutic alliance.[4] He urges psychiatrists to identify ways in which these patients' symptoms are strengths and to then share this view with them.[4,5] "[O]ne needs," he says, "to convey respect while inevitably feeling with another part of one's mind the emptiness of the patient's claim."[4] He explains, "The widespread concentration on pathology, especially before an alliance is cemented, is not only demoralizing, but it deprives the clinician of an ally."[4] According to Havens, a clinician might say in response to a patient's sharing a grandiose thought, for instance, "How wonderful!"[5]

The gains from psychiatrists sharing partial truths may not be evidence-based.[6,7] Havens states, anecdotally, "Clinicians' fears will be relieved by [a positive result]."[4] Empirical testing of Havens's approach may not even be possible. Havens says that for his approach to be successful, psychiatrists must genuinely believe that their patients' symptoms are strengths.[4,5] If he is right, this genuineness may be impossible experimentally to discern!

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Though such approaches may not be empirically proven, psychiatrists still may find them useful. One patient I saw, for example, reported that she felt emotionally attached to inanimate objects. I knew from prior meetings with her that she had extremely warm relationships with all her adult children. "Of course!" I said. "Your exceptional capacity for caring has, I am sure, spilled over!"

Forming a relationship by using such half-truths, despite these possibly representing, ethically, lies, is in Havens's view the most critical first step in treating patients with schizophrenia.[4] These patients, he asserts, are more likely to feel isolated due to their symptoms, and thus are more likely to be alone.[4] If a psychiatrist reframes how a patient regards his or her heightened paranoid thoughts so that he or she sees these thoughts as possible strengths, this may enable the psychiatrist to build a stronger patient alliance, which may in turn help the patient feel less isolated and alone.

2. SUPPORTING THE "RISKY" AMBITIONS OF PATIENTS WITH SCHIZOPHRENIA

An emerging shift in both clinical thinking and the underlying ethics of psychiatry is placing greater emphasis on the quality of life for patients with schizophrenia, as opposed to primarily trying only to give them relief from their symptoms.[8–11] One way to improve a patient's quality of life is by allowing more input by the patient regarding his or her care.

Some patients with schizophrenia are exceptionally ambitious. This may cause some conflict for them and for their psychiatrists. A patient with schizophrenia may wish to pursue a competitive career, for example, that seems to the psychiatrist to be beyond the patient's capabilities due to certain limitations (e.g., intellectual capabilities), as suggested by what the patient has been able to do in the past. To pursue this wish, the patient runs the risk of exacerbating the symptoms of schizophrenia; yet to not do so may diminish the quality of his or her life by not pursuing a lifelong dream. The psychiatrist faces a dilemma when treating such a patient. Does he or she support the patient's autonomous wish, which may add value to the patient's life? Or does the psychiatrist counsel the patient against pursuing such an ambitious task, so as to avoid the risk of exacerbating the illness? Perhaps the psychiatrist should be less paternalistic in a case like this by giving more moral weight to what the patient wants to attempt. Even though the psychiatrist may anticipate that the ambitious pursuit of a particular goal by the patient may possibly make the patient's schizophrenia worse, it may be that the psychiatrist, notwithstanding this, should support the patient in taking this greater risk in support of the patient's hope that this will result in him or her having an improved quality of life.

Shared decision making[13,14] is an approach some psychiatrists use with patients with schizophrenia. Using this approach, the

psychiatrist provides the patient with more information and involves him or her more in treatment decisions. This approach, according to Hamann,[13] "explicitly goes beyond informed consent." It aims to decrease "the informational and power asymmetry between doctors and patients by increasing the patient's information and control over treatment decisions."[13] This may involve the use of directional aids. These aids may depict for the patient the relative pros and cons of different scenarios (e.g., switching to a different antipsychotic drug), and then the choice is made to a greater extent by the patient.[13]

Respecting patients by respecting their autonomy is a value independent of actual consequences. It may be that this value should prevail, even over a psychiatrist's more traditional value of protecting patients, despite the fact that patients with schizophrenia may be more prone to losing decision-making capacity.

3. ASKING A PATIENT WITH SCHIZOPHRENIA WHETHER HE OR SHE WANTS TO WRITE PSYCHIATRIC ADVANCE DIRECTIVES

I have mentioned advance directives in the context of truth-telling. Analogously, a psychiatrist can ask a patient with schizophrenia who still has decisional capacity what his or her wishes are regarding his or her care should he or she lose decisional capabilities at a later time. These psychiatric advance directives enable the psychiatrist to pre-determine several future outcomes, including where the patient will be hospitalized, which psychiatrist will treat the patient, and what medications will be given to the patient.[15–21] By allowing the patient to participate in these decisions, the psychiatrist is respectful of the patient's autonomy and also able to provide optimal medical care. Some patients may not want to pursue this option.[13,22] Something to further consider is that a psychiatrist who presents this option to a patient may cause the patient exceptional fear, which could make the patient's schizophrenic illness worse.

4. PERSUADING PATIENTS WITH SCHIZOPHRENIA TO INVOLVE THEIR FAMILY MEMBERS

A substantial advance in the treatment of schizophrenia has been the understanding that psychiatrists can benefit patients with schizophrenia by educating their family members about the harmful effects of criticism and negative emotions, especially when they are expressed in an exaggerated way.[23–27] Family members can further assist a patient with schizophrenia by helping the patient to detect, earlier on, when he or she is "running into trouble," which may help to avoid hospitalization. Moreover, in regard to the importance of quality of life, a patient's family members may contribute to the patient's sense of meaning and joy most uniquely.[28,29] Thus, it may be beneficial if the psychiatrist can persuade a patient to have his or her family maximally involved in his or her care.

Ethically, attempts at persuasion may be regarded as coercion, just as withholding of information may be regarded as lying by omission.[22] Psychiatrists should not deny to themselves that (some degree of) coercing (or lying) is a genuine risk of making certain interventions. Psychiatrists should know that no action, including being coercive or lying, should ever be ethically prohibited on this basis alone without also considering whether there are other competing moral values in a given case that may be more important. Thus, it may be ethically justifiable for psychiatrists to accept even these actions and other (relative) harms in some instances.

To help illustrate the possible justification of using persuasion, psychiatrists may have an ethical obligation to try to persuade a patient with schizophrenia to continue taking his or her antipsychotic medication, even after only one psychotic episode. This is because the likelihood of relapse if the medication is stopped is much higher.[30,31] The losses patients with schizophrenia may suffer due to relapse may be greatest among those who are doing best on medication. This is because they have "more to lose." Accordingly, a psychiatrist's ethical obligation to try to persuade such a patient with schizophrenia to continue taking his or her medications may be increased.

Just as it may be ethically justifiable to encourage a patient with schizophrenia to continue taking his or her medication, a psychiatrist may also have some ethical obligation to try to persuade a patient with schizophrenia to involve his or her family more in his or her care. This may be considered coercive, but in the end, it will probably help the patient have a better quality of life.

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5. PRODROMAL SCHIZOPHRENIA

Perhaps the most difficult ethical question raised in regard to the treatment of patients with schizophrenia over the last decade is if or when a psychiatrist should tell a patient that he or she is at an increased risk of developing schizophrenia. Furthermore, if the psychiatrist does inform the patient of the risk to develop schizophrenia, another ethical dilemma is whether or not to initiate some form of pharmacological treatment for the patient.[32–34]

Adolescents, for example, sometimes have symptoms and a family history that, together, suggest a greater possibility of subsequently developing schizophrenia. Prodromal or risk factors of schizophrenia are presently regarded as fitting into one of the following three categories: attenuated positive symptoms, brief intermittent psychotic symptoms, and a steep decline in functioning, together with a family history of schizophrenia. Suggestive symptoms may also include disturbances of perception and thought, suspiciousness, and grandiosity.[37]

It is still uncertain which persons with prodromal findings will actually progress to schizophrenia, and less than half of these people actually do.[35–39] Different prodromal features may have different rates of conversion, but which features develop at what rates is not fully known.

Some psychiatrists believe that telling persons that they are at risk for developing schizophrenia, much less treating them, is not necessary. "Risk for schizophrenia is generally not mentioned to either patients or family members, since we don't believe the available information justifies such use of diagnostic labels with only attenuated symptoms."[40]

Others feel this same way because they believe that far too many of these persons would later turn out to be "false positives" for schizophrenia. Disclosing the full truth may scare these patients and their families profoundly. In addition, some psychiatrists feel that such knowledge would create exceptionally harmful stigma.[40,41] The stress from being scared and from the stigma may actually "fuel" the development of schizophrenia if a patient is at all predisposed.[37]

Informing a patient of his or her prodromal state may become a self-fulfilling prophecy.

Still other psychiatrists believe that the risks of not treating a patient with prodromal symptoms of schizophrenia are potentially profound, and that whatever can be done to keep the schizophrenia from emerging should be done.[42] Efforts at preventing schizophrenia could include, for example, attempts to reduce the sources of stress patients experience in their external environments, psychotherapy, use of antidepressants or anti-anxiety drugs, and the prophylactic use of antipsychotic medications.

Still others favor using what might be considered a compromise solution. They may encourage a patient to reduce environmental stresses as much as possible and/or to use antidepressants or anti-anxiety medications.[43]

Here, an additional ethical question to consider is what effect would telling or not telling a patient that he or she may develop schizophrenia have on the patient/psychiatrist relationship. This would be the question that Havens would give paramount importance.

Perhaps the psychiatrist could use an ethical "sliding scale." If he or she uses this approach, he or she could vary what to say and do with each individual patient, depending on additional prognostic factors. These factors might include a patient's insight, the strength of a patient's relationships with family members (or others who would support the patient), and the strength of the relationship the patient has with his or her psychiatrist. When using this approach, however, the psychiatrist should be mindful not to make idiosyncratic judgments, which may be ethically problematic.

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CONCLUSION

Psychiatrists treating patients with schizophrenia may face ethical conflicts. These conflicts often are between helping these patients maximally and respecting their autonomy optimally.

The current consensus is that the value of respecting a patient's autonomy generally should prevail, even when a patient may potentially do worse medically.[44] Psychiatrists, however, should always carefully consider what moral weight should be given to the values of doing good and avoiding harm, which were given more weight in the past when psychiatrists generally were more paternalistic. This should particularly be the case when they treat patients with schizophrenia since these patients' decision-making capacities are likely to be impaired.

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